

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33565

State File No. 9148
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days
(Specify whether
In this community 25 years
years, months or days)

3. (a) PRINT
FULL NAME

Julia Belle Smith

3. (b) If veteran,
name war Mar

3. (c) Social Security
No. No.

4. Sex Female 5. Color or race Col.
6. (a) Single, widowed, married. 2 divorced
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if
alive Dead years
7. Birth date of deceased Feb. 3 1882
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 8 10 hr. min.

9. Birthplace Richmond, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Issac Baker
13. Birthplace Richmond, Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Julia Belle Baker
15. Birthplace Richmond, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Lucille Smith

(b) Address 4375 N. Market St.

17. (a) Burial (b) Date thereof Oct. 18 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Father Dickson

18. (a) Signature of funeral director Lucille Smith

(b) Address 4247 W. Lafayette Ave.

19. (a) OCT 18 1943 (b) Dr. F. B. Breda
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No. 4315 N. Market
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 13,
year 1943 hour 7 minute 20 P. M.

21. I hereby certify that I attended the deceased from October 1,
19 43 to October 13, 19 43
that I last saw him EX alive on October 13, 19 43
and that death occurred on the date and hour stated above.

Immediate cause of death
Cardiac Hypertrophy (Autopsy) Duration Unk.

Due to _____

Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

Signature S. E. Smith (M. D. or other) _____
Address 2601 Whittier Date signed 10/14/43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

William C. McDowell....., Registered Apprentice No.....
working under my personal supervision.

Signed William C. McDowell

Licensed Embalmer No. 2154

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.